STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
DIVISION OF CHILD MENTAL HEALTH SERVICES
OUTPATIENT AND RELATED NON-RESIDENTIAL PROGRAMS

CLIENT BILLING/ACTIVITY FORM

Client Name _____ DOB _____

Primary DSM IV Diagnosis (Code) _____

Provider/Agency_____ _____ Primary Therapist _____

Program: IOP WRAP CRISIS OUTPATIENT

Authorization Date From _____/_____/_____ To _____/_____/_____

Billing Dates From _____/_____/_____ To _____/_____/_____

Admission Date: _____/_____/_____ Authorization Number _____

SERVICE DATE	DIRECT SERVICE CODE	THERAPIST BILLING CODE	LENGTH OF SESSION	ASSESSED CLIENT FEE	AMOUNT DUE
TOTALS					

Total number of un-billable indirect services (case management) provided for this client in this month _____. These must be documented in the client file.